

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## DEPARTMENT OF PUBLIC HEALTH AND WELFARE

**63-021567**

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **4928**

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

**FILED MAY 17 1963**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Lutheran Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>1915a Miami</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Thelma</b> Middle <b>O.</b> Last <b>Flesher</b>			4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>1963</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/16/03</b>	9. AGE (last birthday) <b>60</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeping</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (City, and state or country) <b>Indiana</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>Sculler Wooldrige</b>		13b. MOTHER'S MAIDEN NAME <b>Rebecca Ann Gander</b>	
14. NAME OF HUSBAND OR WIFE <b>John Flesher</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		17. INFORMANT Address <b>John Flesher - 1915a Miami</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable pulmonary Embolus</b> Chronic Mitral Endocarditis DUE TO (b) <b>410x</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 day</b> <b>Severe</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of Item 18.)
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20c. TIME OF INJURY Hour <b>1958</b> Month, Day, Year <b>1963</b> a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>St. Louis</b>	COUNTY <b>St. Louis</b>	STATE <b>Missouri</b>
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21. I attended the deceased from <b>1958</b> to <b>1963</b> and last saw her alive on <b>May 6, 1963</b> Death occurred at <b>2:10 A.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>Ralph Berg MD</b> (Do not use title)	22b. ADDRESS <b>3203 S. Grand</b>	22c. DATE SIGNED <b>5/6/63</b> (State)
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>May 8, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis County, Missouri</b>
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24. FUNERAL DIRECTOR <b>WACKER-HELDERLE-3634 Gravois Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>MAY 7 1963</b>	26. REGISTRAR'S SIGNATURE <b>Rod Smith, M.D.</b>
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USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer \_\_\_\_\_

Signed

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.